

APPLICATION FOR REINSTATEMENT

Name of Insured _____ Policy Number _____

Address _____

Address _____ Phone Number _____

In consideration of the premium paid and the answers to the questions below, I hereby request reinstatement of the above policy. I declare that the answers to the following questions are true and complete to the best of my knowledge and belief and that the answers are deemed to be representations and not warranties.

(If additional space is required, attach a separate sheet).

1. What is your present occupation? (Give exact duties)

2. To the best of your knowledge and belief, do you or any other person insured under the policy have any adverse health conditions, impairments or disabilities? Yes No If yes, give complete details.

SINCE THE DATE OF ISSUE OF THIS POLICY:

3. Have you or any other person insured under the policy had any illness, injury, consulted or been treated by any physician? Yes No If yes, give details including date, duration and complete name and address of attending physician.

4. Have you or any other person insured under the policy made application for life or health insurance or for reinstatement that was postponed, declined or modified as to kind, amount or rates? Yes No If yes, give complete details.

5. Have you or any other person insured under the policy been an airplane pilot or received instructions in flying, or contemplate doing so? Yes No If yes, give details and enclose aviation form.

6. Have you or any other person insured under the policy been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or immune deficiency related disorders? Yes No

7. In the past year have you or any other person insured under the policy smoked cigarettes? Yes No If yes, give complete details including name of the person.

8. In the past 3 years have you or any other person insured under the policy used tobacco in any form? Yes No If yes, give complete details including name of person.

I hereby certify that the foregoing statements and answers are correct and true to the best of my knowledge and belief and have been made by me to induce the Company to reinstate said policy. I agree (1) that the policy shall not be reinstated until this application has been approved by the Company: except, that if money is paid with this application, coverage will take effect only in accordance with the terms of the "conditional premium receipt"; (2) that if the policy is reinstated, no statement made herein shall be used by the Company to contest liability after the reinstated policy has been in force during the lifetime of the Insured for a period of two years from the date of such reinstatement; and (3) to accept return of any amount paid herewith should the Company decline to approve this application.

Dated at _____ this _____ day of _____, 20 _____

X

Signature of Witness

X

Signature of Spouse if to be Insured

X

Signature of Insured

X

Signature of Owner, if other than Insured

CONDITIONAL PREMIUM RECEIPT

CONDITIONAL PREMIUM RECEIPT – I/We understand and agree that no insurance will be in effect before reinstatement of the Policy is approved by the Company and I/We receive written notice of such approval unless all Conditions set forth below are met. If all Conditions are met and my/our death occurs before reinstatement is approved by the Company, then there shall be coverage but only in accordance with the provisions of this receipt and any Policy provisions not in conflict with it. If the Policy cannot be reinstated as originally issued, then all premiums paid will be returned and any coverage under this Receipt will terminate.

CONDITIONS FOR COVERAGE – 1) All information given by me/us in the application must be true and complete to the best of my/our knowledge and belief; 2) The Company must find the person(s) to be insured acceptable on the same risk basis as originally issued according to its underwriting rules; 3) At least one month's premium for the Policy applied for must be paid with the application, but not to exceed the amount of premium required for \$500,000 of coverage.

EFFECTIVE DATE OF COVERAGE – Any coverage under this Receipt will become effective on the latest of the following: 1) Date of this Application; or 2) The first medical examination initially required or the second medical examination if required by the Company's published underwriting rules due to the Proposed Insured's age or amount of Insurance applied for, in connection with this application.

LIMITS OF COVERAGE – The amount applied for and for which premium had been paid, but not to exceed \$500,000 for all coverage applied for under this application.

I hereby acknowledge that I have read and I understand the conditional coverage under this receipt and understand these conditions cannot be changed by any agent of the Company, as evidenced by my/our signature below.

Dated at _____ this _____ day of _____, 19 _____
City, State and Zip Code

_____ Name of Minor Child	<u>X</u> _____ Signature of Proposed Insured or Parent of Minor Child
<u>X</u> _____ Signature of Owner if other than Proposed Insured	<u>X</u> _____ Signature of Spouse if to be Insured

AGENT CERTIFICATION

I certify that: (1) I personally have asked and recorded completely and accurately the answers to all questions on this application; and (2) I saw the applicant sign the application and that to the best of my knowledge and belief all answers on all completed parts are true; and (3) I know of nothing affecting the risk that has not been recorded herein; and (4) I have read and explained to the applicant (s) the provisions of any Conditional Premium Receipt I have given for any premium submitted with this application. I have not made any proposal to or agreement with anyone whereby the applicant or any other person has received directly or indirectly, in settlement of the premium on the proposed insurance, any concession or rebate from the regular premium, and I assume full responsibility for the delivery to the Company of payment of any premium submitted by the applicant in connection with this application.

<u>X</u> _____ Signature of Licensed Agent	_____ Date	_____ Phone Number
_____ Print Name of Licensed Agent	_____ Agent Code Number	_____ Distribution Number

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NATIONAL BENEFIT LIFE INSURANCE COMPANY

HOME OFFICE: ONE COURT SQUARE, LONG ISLAND CITY, NY 11120-0001

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, Veteran's Administration or government facility, insurance company, the Medical Information Bureau or other organization, institution or person having any records or knowledge about me to provide to national Benefit Life Insurance Company or its reinsurers any such medical or personal information and to testify as to such information, all to the extent permitted by law. As part of our regular underwriting procedure, an investigative consumer report may be obtained which will contain personal information concerning an individual's character, habits general reputation, personal characteristics and mode of living. This information may be obtained through personal interviews with your neighbors, friends, associates and acquaintances. Medical information includes the diagnosis, treatment and prognosis with respect to any physical or mental condition, as well as the use of drugs or alcohol. Although we generally maintain confidentiality of information obtained, we may request to be interviewed in connection with the preparation of the report. Upon written request to us at the address listed above, further detailed information on the nature and scope of the report will be provided. Upon request, you may obtain a copy of your investigative consumer report from the Consumer Reporting Agency. I understand that the information obtained by use of this Authorization will be used to determine eligibility for insurance. I know that I or my legal representative may request to receive a copy of this Authorization. A photographic copy of this Authorization shall be as valid as the original and will be valid for two and one half (2-1/2) years from the date this application was signed.

Signed this _____ day of _____, 20_____.

Name of Minor Child

X _____
Signature of Proposed Insured or Parent of Minor Child

X _____
Signature of Spouse if to be Insured

Print Name of Proposed Insured or Parent of Minor Child

Print Name of Spouse it to be Insured